

# E-filing via AQS

for

## Department of Defense

Presentation adapted from a DOL presentation

# Forms available through AQS e-File

- CA-3 - Report of Work Status
- CA-7 - Claims for Compensation
- CA-7a - Time Analysis Form
- CA-7b - Leave Buy Back Worksheet

# Forms available through AQS e-File

- CA-3 - Only forms submitted through e-File process will be accepted. **No hard copy forms will be processed**
- CA-7, CA-7a, CA-7b – Either hard copy **OR** e-File forms will be accepted
- Just like CA-1s and CA-2s, the Agency must retain the original signed version of the CA-7, CA-7a, CA-7b form in the employees case file

# Benefits of e-Filing

- Agency (through the Agency Query System) and claimants (through the Claimant Query System) will know within 24 hours whether OWCP has received an e-Filed CA-7
- E-Filing CA-3s will reduce the possibility and/or severity of overpayments
- The CA-3 will also reduce the number of RTW cases placed into early nurse case management due to quicker input of RTW info

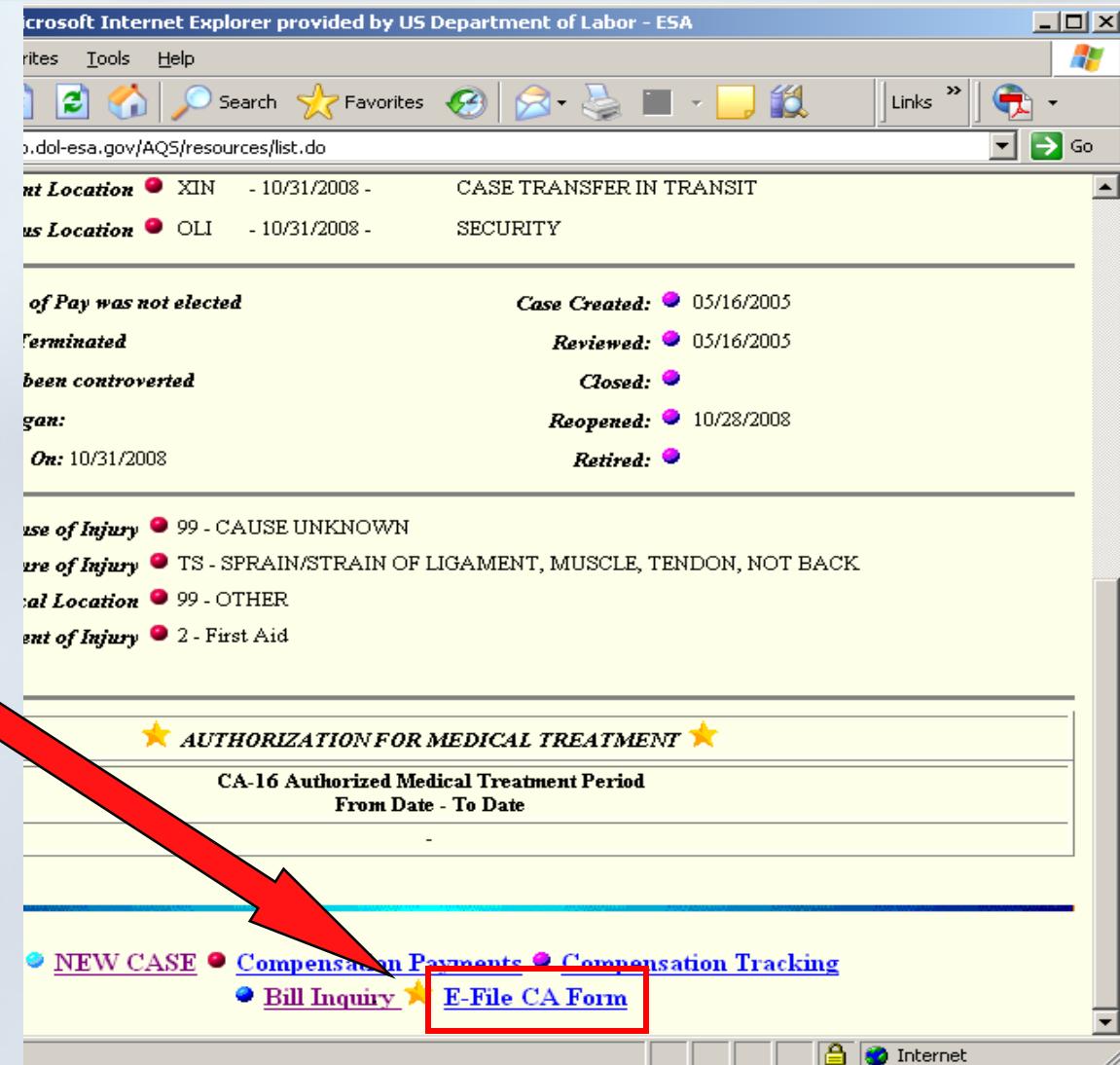
# Applying for e-File

- AQS Users will have to complete a Non-Disclosure Form requesting e-filing access. The form is available on the ICUC Web page
- The AQS User signs the Non-Disclosure Form
- The signed form is faxed to CPMS ICUC Division
- The user's AQS status is verified and the form is completed and signed by the ICUC POC
- The completed form is sent to DOL. DOL will then send back a notification confirming the AQS user is set up to use e-File.

# Actually e-Filing the forms

The ICPA will login to AQS and pull up the case for which a form will be filed

There will be a link at the bottom of the AQS page titled "**E-File CA-Form**". Clicking on the link will start the e-Filing process



# Actually e-Filing the forms

At this point, the ICPA can select from the various form options

Clicking on the desired form will open that form

The E-File CA Forms application requires Microsoft Internet Explorer browser, Version 6.0 or higher.

- [CA7 Form](#)
- [CA7A Form](#)
- [CA7B Form](#)
- [CA3 Form](#)

# What the ICPA will see

The ICPA will then complete the form and click

**“Submit”**

CA7 Form - Microsoft Internet Explorer provided by US Department of Labor - ESA

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Links Go

Address https://aqsweb.dol-esd.gov/AQS/resources/CAForm\_7.do

**Claim for Compensation**

**U.S. Department of Labor**  
Employment Standards Administration  
Office of Workers' Compensation  
Programs

**SECTION 1**

**EMPLOYEE PORTION**

a. Name of Employee      Last      First      Middle      OMB No: 1215-0103  
TESTCASE      TESTCASE           Expires: 09/30/2011

b. Mailing Address (Including City State, ZIP Code)      c. OWCP File Number  
123 UNION      502500000

BOSTON      MA      01752      d. Date of Injury      e. Social Security Number  
Month Day Year      999-99-9991

E-Mail Address (Optional)      f. Telephone No./FAX No.

**SECTION 2** Compensation is claimed for:  
Inclusive Date Range  
From      To      Intermittent?

a.  Leave without pay       Yes       No      Go to Section 3

Done Internet

# What the ICPA will see

A pop-Up will appear denoting that

**Form Submission was Successful**

The screenshot shows a Microsoft Internet Explorer window with the following details:

- Title Bar:** https://esa-cen-tcqs01.esadev.dol.gov:9444 - CAForm - Microsoft Internet Explorer
- Menu Bar:** File, Edit, View, Favorites, Tools, Help
- Content Area:**
  - A red box highlights the message "CA7a Form is submitted successfully". A large blue arrow points from this message towards the top left of the page.
  - The title "AQS Case Compensation Payment History" is displayed with three yellow stars.
  - Logout button is located in the top right corner.
  - Form submission details:
    - AGENCY: 510000 - UNITED STATES POSTAL SERVICE, HEADQUARTERS & HQ FIELD UNITS
    - CASE#: 50250000
    - NAME: TESTCASE, TESTCASE
    - Address: 123 UNION
    - City State Zip: BOSTON, MA 01752
    - Occupation: A0462 - FORESTRY TECHNICIAN
    - Reported Condition: 9999 - OTH/UNS COMPLICATIONS MEDICAL CARE
    - Condition Accepted
    - Form Rec'd: CA1 - 05/16/2005
    - Location: National Office
    - CEID: BAA
    - Injury ZIP: 20260
  - CASE STATUS:** Three yellow stars followed by the text "CASE STATUS".
    - Adjudication Status: AP - 08/20/2008 - Accepted - Periodic Roll Payment
    - Current Case Status: PR - 08/20/2008 - Payment on Periodic Roll
    - Current Location: OLI - 05/16/2005 - SECURITY
  - Links at the bottom:**
    - [CA7 Form](#)
    - [CA7A Form](#)

# How will the ICPA know it worked?

In addition to the immediate pop-up alerting the ICPA that the submission was successful, AQS will update the Payment Tracking page within 24 hours

AQS Case Compensation Tracking ★★★

Logout

AGENCY: 141000 - OTHER ESTABLISHMENTS, BICENTENNIAL COMMISSION  
CASE#: 069000099  
NAME: DOE, JOHN  
Address: 1234 MAIN STREET  
City State Zip: JACKSONVILLE, FL 32204  
Occupation: -

MASTER: SSN: 111-22-4444 SEX: M  
DOB/Age: 01/01/1930 - 78  
DOI: 03/23/2008

Reported Condition: Condition Accepted  
9999 - OTH/UNS COMPLICATIONS MEDICAL CARE 9999 - OTHER AND UNSPECIFIED COMPLICATIONS OF MEDICAL CARE  
Form Rec'd: CA1 - 04/23/2008 Location: Jacksonville CEID: ADD Injury ZIP: 32204

★★★ CASE STATUS

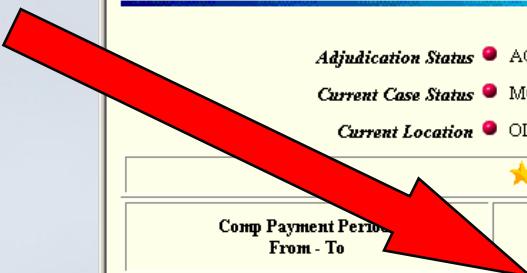
Adjudication Status • AC - 07/24/2008 - Accepted - COP Elected  
Current Case Status • MC - 07/24/2008 - Medical Benefits Only  
Current Location • OLI - 07/24/2008 - DESC MISSING

★ COMPENSATION PAYMENT TRACKING ★

Comp Payment Period From - To	Date CA-7 Received by OWCP	Decision Code, Date, & Description	Date IW Signed
05/12/2008 - 05/30/2008	2008-07-23	- Undecided	2008-04-20

• NEW CASE • Compensation Payments • Compensation Tracking  
• Bill Inquiry

Done Internet



# Pre-Populated Fields on CA-7

## Pre-Populated Fields in Section 1

All pre-populated fields will be in Section 1 of Form CA-7 (pictured below). The pre-populated sections will be in fields "a" through "e" of Section 1.

- \* Note that the E-Mail section of field "b" will not be pre-populated and will remain blank, but editable.
- \* Item "f" was left out because there may not always be a telephone number on file. OWCP didn't want to create errors if no number was on file.

Claim for Compensation		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs			
SECTION 1 EMPLOYEE PORTION					
a. Name of Employee	Last	First	Middle	OMB No.	1215-0103
b. Mailing Address (Including City State, ZIP Code)				Expires:	10/31/2008
			c. OWCP File Number		
			d. Date of Injury		
			Month Day Year	e. Social Security Number	
E-Mail Address (Optional)				f. Telephone No./FAX No.	
SECTION 2 Compensation is claimed for:					
Inclusive Date Range		From	To	Intermittent?	

# Major Differences Web form vs. Paper

**Section 5** (Dependents). On the web form, the AQS user is asked to enter the dependent's **Last Name, First Name and Middle Initial**, in that particular order. This is different than the paper form, which only asks for the dependent name(s). Since there is no format to follow on the paper form, most people usually handwrite the first name followed by the last name, but on the web form DOL asks that your ICPAs please follow the format described above and depicted in the screen shot below.

The screenshot shows a portion of the AQS web form. At the top, a question asks if the user has "Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?" with two radio button options: "Yes - Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)" and "No - Complete Section 7".

**SECTION 5** List your dependents (including spouse):

Last	First	Middle	Social Security	Date of Birth	Relationship	Living with you?
<input type="text" value="Enter Dependent Last Name"/>						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> For depende nt not
						<input type="checkbox"/> living with you complet
						<input type="checkbox"/> items a and b below.

a. Are you making support payments for a dependent shown above?  Yes  No If Yes, support payments are made to:

# Major Differences Web form vs. Paper

**Above Section 8.** At the top of the second page on the paper form, filers are advised that they need not complete Sections 8 through 15 if the CA-7 is a subsequent submission. For ease of electronic filing, the web form asks the AQS users to check a box indicating whether the submission is for an initial form or a subsequent form. If the AQS user checks the “Initial” box, Sections 8 through 15 are required fields. If the AQS user checks the “Subsequent” box, only Sections 12 through 15 are required.

Address https://eoweb.dol-esa.gov/AQ5/resources/CAForm\_7.do Form CA-7  
Go

the “Subsequent” box, only Sections 12 through 15 are required.

Employing Agency Portion

For first CA-7 claim sent, complete sections 8 through 15.  
For subsequent claims, complete sections 12 through 15 only.

Is this the initial or a subsequent CA-7? Initial  Subsequent

SECTION	Show Pay Rate as of	Additional Pay	Additional Pay	Additional Pay
8				
Date of Injury:	Base Pay	Type <input type="text"/>	Type <input type="text"/>	Type <input type="text"/>
Date:	<input type="text"/> \$ <input type="text"/> per <input type="text"/>	\$ <input type="text"/> per <input type="text"/>	\$ <input type="text"/> per <input type="text"/>	\$ <input type="text"/>
Grade:	<input type="text"/> Step: <input type="text"/>			

# Fields on CA-7a

## **Pre-Populated Sections:**

1. Name of Employee
  2. SSN
  3. OWCP File No.

Time Analysis Form		<input type="button" value="Reset"/>	<input type="button" value="Print"/>	U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs		
Employee Statement - Please carefully read instructions on reverse before filling out this form.						
1. Name of Employee: (Last, First, Middle)		2. SBN	3. OWC File Number			
<input type="text"/>		<input type="text"/>	<input type="text"/>			
4. Period Covered by This Form:		5. Total Hours Claimed for LWOP: <input type="text"/> for Leave BuyBack <input type="text"/>				
From: <input type="text"/> To: <input type="text"/>						
6. In "Type of Leave Used" column, use codes "S" = Sick, "A" = Annual, "O" = Other. If Compensation is claimed for date, indicate "Yes" in "Compensation Claimed" column.						
Date(s)	Compensation Claimed?	Number of Hours			Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
		LWOP	Worked	Holiday	Leave	
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<b>Totals</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Signature of Claimant: <input type="text"/>					Date Signed: <input type="text"/>	
7. Agency Statement/Certification: I certify the above is accurate, except as follows:					<input type="text"/>	
Signature of Agency Official: <input type="text"/>					Date Signed: <input type="text"/>	

# Fields on CA-7b

## Pre-Populated Sections:

1. Name of Employee
2. SSN
3. OWCP File No.

Leave Buy Back (LBB) Worksheet/  
Certification and Election

**U.S. Department of Labor**  
Employment Standards Administration  
Office of Workers' Compensation Programs

Employee Statement - Please carefully read instructions on pages 3 and 4 before filling out this form.

A. Name of Employee: ( <i>Last, First, Middle</i> )	B. OWCP File Number:
C. Social Security Number:	

## Required Sections:

Dates and Signatures

# Fields on CA-3

## Pre-Populated Sections:

- OWCP Case No.
- Claimant's Name
- DOI

REPORT OF WORK STATUS      U.S. Department of Labor  
Employment Standards Administration  
Office of Workers' Compensation Programs

To the Employing Agency: This form should be completed and submitted to OWCP each time a claimant stops work, reduces their work hours or returns to work following a work-related injury. The form should be completed even if the claimant has not yet filed form CA-7 or CA-2a. **This form does not replace form CA-7 or CA2a.**

OWCP CASE# \_\_\_\_\_ CLAIMANT'S NAME: \_\_\_\_\_ DOI \_\_\_\_\_

COP WORK STATUS INFORMATION

1. DATE STOPPED WORK (during COP): \_\_\_\_\_ (Include reductions in work schedule)  
 Stopped Work After CA-1 FILED but During COP Eligibility Period
2. RETURN TO WORK DATE (during COP): \_\_\_\_\_ (Must complete RTW Section below)

THE CLAIMANT RETURNED TO WORK WITH THE FOLLOWING STATUS:

\_\_\_\_Full Time Regular Duty: No Restrictions  
\_\_\_\_Full Time Modified Duty: With Restrictions  
\_\_\_\_Part Time Regular Duty: No Restrictions for \_\_\_\_ Hours per Day  
\_\_\_\_Part Time Modified Duty: With Restrictions for \_\_\_\_Hours per Day

POST COP INFORMATION

1. DATE EMPLOYEE STOPPED WORK: \_\_\_\_\_ (Include reductions in work schedule)
2. REASON FOR WORK STOPPAGE:  
\_\_\_\_WITHDRAWAL OF LD  
\_\_\_\_RECURRANCE of Temporary Total Disability (TTD)  
\_\_\_\_ADMINISTRATIVE (explain) \_\_\_\_\_  
\_\_\_\_OTHER (explain) \_\_\_\_\_  
\_\_\_\_SURGERY Y N SURGERY DATE \_\_\_\_\_  
CA-7 FILED? YES NO      CA-2a FILED Yes NO
3. RETURN TO WORK DATE: \_\_\_\_\_ (Must complete RTW Section below)

THE CLAIMANT RETURNED TO WORK WITH THE FOLLOWING STATUS

\_\_\_\_Full Time Regular Duty: No Restrictions  
\_\_\_\_Full Time Modified Duty: With Restrictions  
\_\_\_\_Part Time Regular Duty: No Restrictions for \_\_\_\_ Hours per Day  
\_\_\_\_Part Time Modified Duty: With Restrictions for \_\_\_\_Hours per Day

\* JOB OFFER ACCEPTED ON: \_\_\_\_\_ (Please forward copy to OWCP)  
\* WORK RESTRICTIONS HAVE CHANGED. SEE MEDICAL DATED \_\_\_\_\_

NOTES: \_\_\_\_\_

EMPLOYER INFORMATION

AGENCY \_\_\_\_\_

INJURY COMPENSATION SPECIALIST/DATE \_\_\_\_\_

PHONE \_\_\_\_\_

## Required Sections:

- Agency
- Injury Compensation Specialist/Date
- Phone